STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445502	A. BUILDING **01 - MAIN** B. WING _____	R **08/17/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WATERS OF SMYRNA, LLC	**202 ENON SPRINGS ROAD EAST** **SMYRNA, TN 37167**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS A Life Safety revisit survey was conducted on 08/17/2018 for all previous deficiencies cited on 06/11/2018. All deficiencies have been corrected, and no new noncompliance was found. The facility is in compliance with all regulations surveyed.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445502	A. BUILDING _____ B. WING _____	R 08/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WATERS OF SMYRNA, LLC	202 ENON SPRINGS ROAD EAST SMYRNA, TN 37167

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{E 000}	Initial Comments A Life Safety revisit survey was conducted on 08/17/2018 for all previous deficiencies cited on 06/11/2018. All deficiencies have been corrected, and no new noncompliance was found. The facility is in compliance with all regulations surveyed.	{E 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
POC #1	445502	A. BUILDING 01 - MAIN B. WING	06/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WATERS OF SMYRNA, LLC	202 ENON SPRINGS ROAD EAST SMYRNA, TN 37167

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 222 SS=D	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and	K 222	K 222 1. What corrective action(s) will be accomplished for the deficient practice? The facility's Maintenance Director will reconfigure door latch height to be at or below 48 inches to courtyard gate exits by 6/22/18. 2. How will you identify other door latches that may be affected by the same deficient practice? The facility's Administrator audit all facility door latches on 6/11/18 to ensure no other doors were affected by this deficient practice. This audit yielded no further concerns. 3. What measures will be put into place or what systematic changes will you make to ensure that the deficient practice does not recur? On 6/11/18, the facility's Administrator provided face to face re-education to the facility's Maintenance Director regarding Americans with Disabilities Act requirements with an emphasis on door latch height. 4. How will the corrective action(s) be monitored to ensure the deficient practice will not recur? Beginning on 6/18/18, the facility's Maintenance Director will conduct an audit of all egress doors weekly x 4 weeks. If no concerns noted, then decrease audit to every month x 2 months. The facility's Maintenance Director will present the	7/28/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	6/25/18

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

received 6-25-18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445502	A. BUILDING 01 - MAIN B. WING	06/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WATERS OF SMYRNA, LLC	202 ENON SPRINGS ROAD EAST SMYRNA, TN 37167

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 222	Continued From page 1 ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observations, the facility failed to maintain the egress doors. The findings include: Observation on 06/11/2018 at 2:30 PM, revealed door latch height higher than 48 inches on all of the courtyard gate exits. NFPA 101, 19.2.2.2.1 (2012 Edition), NFPA 101, 7.2.1.7.1 (2012 Edition) The maintenance director was present for the findings which were later acknowledged by the administrator during the exit conference on 06/11/2018.	K 222	facility's QAPI Committee with a summary of audits during the facility's monthly QAPI Committee meeting for further review and/or recommendation. K 223 1. What corrective action(s) will be accomplished for the deficient practice? On 6/11/18, the facility's Maintenance Director adjusted the tension screws to the door latch for the cross corridor by room 405 which remedied the deficient practice.	7/20/18
K 223	Doors with Self-Closing Devices	K 223		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445502	A. BUILDING 01 - MAIN B. WING	06/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WATERS OF SMYRNA, LLC	202 ENON SPRINGS ROAD EAST SMYRNA, TN 37167

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 223 SS=D	Continued From page 2 CFR(s): NFPA 101 Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 This REQUIREMENT is not met as evidenced by: Based on testing, the facility failed to maintain self closing doors. The finding included: During the fire alarm test on 06/11/2018 at 2:43 PM, revealed the cross corridor by room 405 did not self close and latch within the frame. NFPA 101, 8.3.3.1 (2012 Edition), NFPA 80, 7.1.4 (2010 Edition), NFPA 80 6.1.4.2 (2010 Edition) The maintenance director was present for the findings which were later acknowledged by the administrator during the exit conference on 06/11/2018.	K 223	2. How will you identify other door latches that may be affected by the same deficient practice? On 6/11/18, the facility's Maintenance Director conducted an audit of all corridor doors to ensure timely self-release and proper latch. No other concerns were noted. 3. What measures will be put into place or what systematic changes will you make to ensure that the deficient practice does not recur? On 6/11/18, the facility's Administrator provided face to face re-education regarding the requirements of self-closing smoke barrier doors during the activation of a fire alarm. 4. How will the corrective action(s) be monitored to ensure the deficient practice will not recur? Beginning on 6/18/18, the facility's Maintenance Director will conduct an audit on all smoke barrier doors weekly x 4 weeks to ensure timely self-closure and latch during the activation of a fire alarm. If no on-going concerns noted, then decrease audit to monthly x 2 months. The facility's Maintenance Director will present the facility's QAPI Committee with a summary of audits during monthly QAPI Committee meeting for further review and/or recommendations.	
K 923 SS=D	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage	K 923	K 923 1. What corrective action(s) will be accomplished for the deficient practice? On 6/11/18, the facility's Maintenance	7/28/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445502	A. BUILDING 01 - MAIN B. WING	06/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WATERS OF SMYRNA, LLC	202 ENON SPRINGS ROAD EAST SMYRNA, TN 37167

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 923	Continued From page 3 Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on an observation, the facility failed to properly store the oxygen bottles.	K 923	Director secured the 3 noted unsecure oxygen storage bottles. 2. How will you identify other unsecured oxygen storage bottles that may be affected by the same deficient practice? On 6/11/18, the facility's Administrator conducted an audit on all oxygen storage rooms to ensure proper securing of stored oxygen bottles. No other concerns were noted. 3. What measures will be put into place or what systematic changes will you make to ensure that the deficient practice does not recur? Beginning on 6/18/18 and to be completed by 7/1/18, the facility's Maintenance Director, Administrator, and/or Administrative Staff designee will provide 100% staff education with post-test regarding proper storage of oxygen bottles. 4. How will the corrective action(s) be monitored to ensure the deficient practice will not recur? Beginning on 6/18/18, the facility's Maintenance Director, Administrator, and/or Administrative Staff designee will conduct an audit of all oxygen storage rooms daily x 4 weeks to ensure proper oxygen bottle storage. If no on-going concerns noted, then decrease audit to 3 x per week x 2 months. The facility's Maintenance Director will present the facility's QAPI Committee with a summary of audits during the facility's monthly QAPI Committee meeting for further review and/or recommendations.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445502	A. BUILDING 01 - MAIN B. WING	06/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WATERS OF SMYRNA, LLC	202 ENON SPRINGS ROAD EAST SMYRNA, TN 37167

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 923	Continued From page 4 The finding included: Observation on 06/11/2018 at 10:17 AM, revealed 3 oxygen storage bottles not secured in the 200 hall oxygen storage room. NFPA 99 11.3.2.1 (2012 Edition) The maintenance director was present for the findings which were later acknowledged by the administrator during the exit conference on 06/11/2018.	K 923		